STUDENT MEDICAL CONDITION NOTIFICATION
ALLERGY

Dear Parent,

The school records indicate that your child _____ has been diagnosed with the following medical condition(s):

_____

_____

In order to prepare the staff for a possible emergency concerning your child, the school staff must be made aware of your child's medical condition. Therefore, the school is asking for your permission to confidentially notify the teachers and/or staff members and/or transportation of your child's condition, in order to protect your rights, your child's safety and comply with Florida Statute 1002.22 and 381.0056. The school understands this can be a sensitive situation and assures you that this information will be kept as confidential as possible.

Sincerely,

_____

Principal

_____School

PLEASE SIGN AND RETURN TO YOUR CHILD'S SCHOOL

I hereby give permission for confidential written notification to your staff of my child's medical condition.

Parent Signature: _____ Date: _____

GRACE EDUCATION ACADEMY

ALLERGY CARE PLAN

School Year _____ - _____

Student Name_____ Date of Birth_____

School Name_____ Grade_____ Teacher_____ Bus_____

Contact Information:

Parent/Guardian #1_____ Phone#: Home_____ Work_____

Cell_____ Parent/Guardian #2_____ Phone#: Home_____

Work_____ Cell_____ Emergency Contact_____

Relationship_____ Phone#_____ Emergency

Contact_____ Relationship_____ Phone#_____ Allergy

Specialist_____ Phone#_____

Primary Physician_____Phone#_____

Hospital Choice: Please circle.

Brooksville Regional Hospital Oak Hill Hospital Spring Hill Regional Hospital

Emergency Notification:

Circle the symptoms usually seen for this child (if parent/guardian(s) can't be located, 911 will be called for a student in acute distress). Shortness of Breath/Difficulty Breathing Chest tightness

Chest Pain Wheeze

Dusky Color Lips/Nails Blue in Color

Rash/Hives Straining Neck Muscles

Itching Nasal Flaring (Widening)

Vomiting Diarrhea

Unable to Speak in Complete Sentences Hunched Shoulders

Other_____

Date of Last Allergic Reaction_____

Date of Last Hospitalization_____

Student Name_____

ALLERGY MEDICATIONS AT SCHOOL/HOME

Student Name_____

Name_____Dosage_____Frequency_____

Name_____Dosage_____Frequency_____

Name_____Dosage_____Frequency_____

Rescue Treatment:

Name_____Dosage_____Frequency_____

DOES STUDENT HAVE CONTRACT TO CARRY EPI PEN? _____YES_____NO

Allergic To: Circle all that apply.

Food (list all/bE specific)_____

Insects (be specific)_____

Medications_____

Latex Cats Dogs Mold Sprays Smoke

Environmental Allergies_____

Household Products_____

Seasonal Allergies_____

Other_____

List other emergency procedures for student experiencing allergic signs/symptoms

_____

_____

Parent/Guardian Signature and Date_____

Public Health Nurse Signature and Review Date_____

GRACE EDUCATION ACADEMY

HEALTH CARE ACTION PLAN

Student Name _____ Date _____ _ (Copy to be readily available in classroom and clinic)

EMERGENCY PLAN

IN AN EMERGENCY:

1 . Stay with child

2. Call/ask someone to call Ms. Kim or Dr. Rivera-Tubbs who will assess the child and summon EMS for this child/or the teacher may call EMS.

If you see this: **Do This:**

Based on the child's current condition a **medical emergency** for this child is

Mother's Name: _____ Work (_} _____ Home (_) _____ _ Cell (_} _____ _

Father's Name: _____ Work(_} _____ Home (_} _____ _ Cell (_) _____ _

Emergency Contact Name: _____ Phone Number: _____ _

Preferred Hospital: _____ _

Primary Physician: _____ _

Specialist(s): ----------